MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Princeton Pain Management 3710 Rawlins Dallas, TX 75219	MDR Tracking No.: M4-03-7457-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 19 Fidelity & Guaranty Ins. c/o Flahive, Ogden & Latson 505 West 12th St. Austin TX 78701	Date of Injury: Employer's Name: Cracker Barrel Old Country Store Insurance Carrier's No.: 645C170656

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/28/02	**2/10/03**	**97799-CP**	**$18,231.00**	**$10,878.00**

PART III: REQUESTOR'S POSITION SUMMARY

5/1/03: "Please find enclosed…unpaid bills for services rendered…remain unpaid…DOS 10/28/02 through 2/10/03…for chronic pain management (97799) in the amount of $195.00 per hour…The carrier chose to reimburse us at different and inconsistent rates for each DOS that we billed…We should be reimbursed at 80% because we are not CARF accredited…they have chosen to preauthorize ALL of the treatment but not wanting to reimburse at a fair and reasonable rate. This percentage rate is unacceptable considering the fact that this carrier has paid a portion of this SAME patient's bill @ 80% of what we billed for CPT Code: 97799…proves that this carrier does not have a standard reimbursement protocol and/or rate and they just pick and choose…On pages 92-102 are copies of the EOB's that show where the carrier has reimbursed us @80% to 100% including SEVERAL copies of EOB's from other offices where they have consistently been paying @ 100% as well…"

PART IV: RESPONDENT'S POSITION SUMMARY

7/7/03: "This letter is filed in response to the request for medical dispute resolution…This dispute involves DOS 10/28/02 through 2/10/03 for non-CARF accredited services. Carrier paid $16,284.00 of a $34,512.00 bill leaving $18,231.00 in dispute. The HCP's TWCC-60 lists the payment exception code used at "F," but the correct code…is "M." Carrier reduced the usual and customary charges to a fair and reasonable rate. The HCP makes no effort to provide any evidence, e.g., invoice costs, overhead considerations, etc., for its position that either its charges were fair and reasonable or that carrier's payment was not fair and reasonable."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT Code 97799-CP for dates of service 10/28/02 through 2/10/03 were denied "Chronic Pain Management, M – No MAR, reduced to Fair & Reasonable." (The 'Table of Disputed Services indicated the denial of "F" but no EOB's were found with this denial.)

- According to 133.307 (j)(1)(G) the requestor submitted in copies of redacted examples substantiating their usual and customary charges. Upon review, the pages were not numbered as stated, but were in the medical documentation submitted for review the services rendered as billed.

- The respondent did not submit convincing evidence of the fair and reasonable rate they chose to reimburse the requestor.
- Therefore, the requestor's usual and customary charges billed less 80% for Non-CARF rates ($195.00 per hour x 80% = $156.00 per hourly rate) according to 133.1 (a)(8) and MFG/GI VI, additional reimbursement recommended. Remaining amount due = ($156.00 x 8 hrs x 1 day = $1,248.00 x 20 days =$24,960.00, $156.00 x 7 hrs x 1 day (1/13/03) = $1,092.00, 1 day(1/21/03) @ 6 hrs x $156.00 = $936.00 and 1 day @ 4 hrs x $156.00 = $624.00 = grand total of $27,612.00 –(minus previously paid amount of $16,284.00 =) $**11,328.00**

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $11,328.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Amy Rich	04/14/05
Authorized Signature	Associate Director	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____